one of the following three circumstances: 1) bankruptcy, 2) a physical plant with less than 50 beds that needs replacement, or 3) a physical plant with life safety code problems. This applies if space is currently not available for these beds.

1.314 Payment Rate Year
The payment rate year is the twelve month period from July 1, 2001 through June 30, 2002.

1.315 Patient Day
A patient day is one in which a patient, regardless of pay source, resides in a nursing facility for any part of a calendar day. This includes the day of admission but not the day of discharge. If the day of admission and discharge are the same it will be considered one patient day. Bed hold days reimbursed by the fiscal intermediary or patient are considered a patient day (Medicaid bed hold days must meet the billable criteria identified in Section 1.500.) A patient day can not be counted as both a patient day and a bed hold day.

1.316 Beds for Rate Setting
The beds for rate setting will be calculated as described in Section 3.040.

1.317 Medicaid Days
Only days of care for Medicaid residents that qualify for the nursing home fee-for-service benefit will be considered as Medicaid days for the Medicaid case mix indices (CMI) in section 3.122, the over-the- counter drug allowance in section 3.600 and for the special allowances for facilities operated by local units of government in section 3.775. The facilities' adjusted Medicaid days for the exceptional Medicare/Medicaid utilization incentive in section 3.651 shall include days of care for Family Care clients with a primary payor of Medicaid, Medicaid residents paid for by other states and residents funded by other Medicaid programs such as PACE, and Partnership in addition to days of care for fee-for-service residents.

1.400 NURSING HOME APPEALS BOARD

The Nursing Home Appeals Board is available for redress in the event a facility has extraordinary fiscal circumstances, as defined by statute. With the assistance of the Department, the Appeals Board shall develop written policies to ensure that the criteria required by statute are taken into account.

1.500 BED HOLD DAYS

Hospital bed hold days and therapeutic bed hold leave days will be paid at 85.0% of the full rate for qualifying facilities. A maximum of 15 consecutive days is payable for each hospitalization leave. In order to qualify to bill for bed hold, facilities must meet occupancy criteria below. (Reference: HFS 107.09(3)(j), Wis. Adm. Code).

1.510 Bed Hold Occupancy Requirements
Hospital and/or therapeutic bed hold leave can be billed to the Medicaid Program if the certified provider's occupancy level is an average of 8.0 or fewer vacant licensed beds, or a 95.0% or greater occupancy rate during the calendar month prior to the bed hold leave days. If either test is met, then the subsequent month's bed hold days may be billed. Minimum occupancy requirements for bed hold billing apply to new or expanded facilities. Homes in start-up must meet bed hold occupancy provisions.

Any facility pursuing a phase-down of resident population due to a licensed bed reduction or a phase-out may be exempted from the above occupancy requirements. The phase-down or phase-out and its expected time period must be approved in writing and in advance by the Department before such exemption shall be allowed.

1.520 Calculation of Occupancy for Bed Hold Billing
The occupancy in the month prior to the bed hold leave days shall be the basis for determining if the bed hold days in the subsequent month can be billed. Average vacant beds (for the "8.0 or fewer" test) shall be determined by subtracting the month's average midnight census days from the sum of the average licensed beds less any restricted use beds of each certified provider for the month. The occupancy rate (for the "95.0% or greater occupancy rate" test) shall be determined by dividing the total patient days by the number of licensed bed-days for the month. For this calculation only, licensed bed-days shall not include any restricted use beds. For the purposes of this calculation, bed hold days for any resident if charged at a level equal to or greater than 85% of the normal rate, shall be included as one full patient day.

1.521 Combined Occupancy Test for Multiple Providers
A provider, at its option, may combine the occupancy calculation under Section 1.520 for two or more separately certified facilities if the facilities are located on the same or contiguous property and are fully owned by the same corporation, governmental unit or group of individuals. The election to combine or separate facilities for the occupancy can differ from one month to the next month. Distinct part facilities may also utilize this occupancy test.

1.530 Excludable Licensed Beds

Licensed beds may be reduced for (a) isolation beds, (b) seclusion beds, (c) certain code violations, and (d) renovations in order to calculate the occupancy for bed hold billings. Excluded beds must meet one of the following criteria:

1. Isolation beds must be in rooms qualifying under HFS 132.84(12), Wis. Adm. Code, and used only for the temporary isolation of residents. Excluded licensed beds may not exceed one bed for every 100 beds or fraction thereof, unless more beds are specifically approved by the Department.

2. Seclusion beds (1) must be in a lockable room, the door to which required a licensure waiver, (2) must be used for seclusion only and always be available for seclusion, and (3) must be only used temporarily for calming disruptive residents. Only one licensed bed per seclusion room may be excluded.

3. For code violations, excluded beds must be out-of-use due to life safety code violations cited by the Department. The Department must be notified of such beds.

4. For renovation, licensed beds must be out-of-use due to renovation projects. The excluded beds and the expected time period of the exclusion must be prior approved by the Department.

5. Beds banked under Section 3.060.

6. Restricted Use Beds. Restricted use beds are defined in Section 1.313.

1.540 Documentation

Sufficient documentation by a certified provider assuring the Department that requirements permitting billing for bed hold days have been met must be provided upon request. If a certified provider does not supply sufficient documentation, payments for unsupported billings may be recouped by the Department.

1.550 No Charge to Resident and Third Party

NO RESIDENT OR THIRD PARTY MAY BE CHARGED FOR COVERED BUT UNREIMBURSED BED HOLD OR THERAPEUTIC BED HOLD LEAVE DAYS OR SERVICES OF A MEDICAID RECIPIENT. Beds held for the following leaves are deemed to be Medicaid-covered services, even when a certified provider does not meet the above occupancy requirements:

-- All hospital leaves of absence up through 15 days per hospitalization
-- All leaves for therapeutic visits
-- All leaves for therapeutic rehabilitative programs meeting the criteria under HFS 107.09(3)(j), Wis. Adm. Code.

1.600 RESOURCE ALLOCATION PROGRAM RATES AS A MAXIMUM

The per patient day property allowance stated in an application to the state's resource allocation program under Chapter 150, Wis. Stats., is the maximum allowable payment that may be granted by the Department for applications not involving the addition of beds for the first full year following completion of the project. In an application for approval of additional beds, the per patient day rate(s) stated in an application to the State's resource allocation program under Chapter 150, Wis. Stats., is the maximum allowable reimbursement that may be granted by the Department for the twelve months following licensure of the additional beds. If the Methods generates per patient day rates or per patient day property allowance that are less than those stated in the application, the Department shall use the lower rate(s) or allowance.

This section does not apply to ICF-MR facilities certified after June 30, 1988.

Resource Allocation Program maximums shall be applied for the first full year following completion of a project or the time period specified in the RAP approval.

1.700 CHAPTER 227 ADMINISTRATIVE HEARINGS

A facility may contest a final rate-setting action of the Department by writing to the Department of Administration's Division of Hearings and Appeals at P.O. Box 7875, Madison, WI 53707-7875. The rate approval letter issued to the facility by the Department is the formal written Notice of Action required by the state administrative code (Reference: HFS 106.12, Wis. Adm. Code). The request for hearing must be served within 15 days of receipt of a Notice of Action. It must contain a brief and plain statement identifying every matter or issue contested.

1.800 ADMINISTRATIVE REVIEWS

A facility may request an administrative review of the Department's cost finding decisions prior to the issuance of a rate approval letter. The request must be filed within 30 days of the facility's receipt of the notification of Medicaid nursing home rates and shall be subject to any other procedures or criteria developed by the Department. A facility's failure to file a timely request for an

administrative review shall have no bearing on the facility's right to file a request for administrative hearing under Section 1.700 or an appeal to the Nursing Home Appeals Board under Section 1.400 upon issuance of the rate approval letter. All administrative reviews should be sent to:

David Lund, Nursing Home Section Chief
Division of Health Care Financing
P.O. Box 309
1 West Wilson
Madison, WI 53701-0309

1.900 MEDICARE BILLING

Facilities must bill Medicare for covered services and supplies. Facilities that bill Medicare for applicable Part B services must be dually-certified facilities, and must bill Medicare for Medicare-covered services or supplies prior to billing Medicaid. Providers are expected to bill the Medicare Part B program for any services or supplies for residents covered by that program. Should a provider not exhaust Medicare Part B sources of revenue, then the Department may offset that amount or an estimate of that amount which could be billed to Medicare Part B. This policy applies to facilities which do not bill Medicare at all or do not exhaust Medicare to the extent available for applicable Medicare third-party liability.

SECTION 2.000 PAYMENT RATE ALLOWANCES DESCRIBED

This Methods provides for payments which are divided into seven major cost centers: Direct Care; Support Services; Administrative and General; Fuel and Utilities; Property Tax; Property and Over-the-Counter Drugs. Section 2.000 describes the types of services and costs generally covered by each cost center. The calculation of the payment allowances is described in Section 3.000.

2.100 DIRECT CARE ALLOWANCE

The direct care allowance shall reimburse for allowable facility expenses related to the provision of the following purchased and/or provided services and supplies, (which include, but are not limited to, staff wages, fringe benefits, and purchased services costs) up to maximums discussed in Section 3.100.

2.110 Professional Nursing Services

Professional nursing services shall include all registered nurses, nurse practitioners and licensed practical nurses.

2.120 Supporting Care Services

Supporting care services shall include technical, non-professional resident living staff, volunteer coordinators, nurses aides and ward clerks, activity and recreation staff, and therapy aides and assistants.

2.130 Professional (Non-Medical/Clinical Care) Services

Professional care services shall include: teachers and vocational counselors for residents aged 22 and over, social services, educational and vocational expenses that are part of an active treatment plan in facilities licensed as ICF-MRs, chaplain and religious services, and the non-billable services of pharmacy, x-ray, laboratory, dentists, physicians, physician assistants, licensed registered therapists, chiropractors, psychiatrists, and psychologists. Non-billable services generally include those types of services which are provided to the facility as a whole instead of to an individual resident and/or which are not billable separately to the Medicaid Program per HFS 107, Wis. Adm. Code.

The cost of non-covered services identified in HFS 107, Wis. Adm. Code or Department policies shall not be reimbursed.

Expenses for the time to perform overhead activities related to billable therapy evaluations, procedures and modalities are not to be included in the rate calculation and are not to be considered in the cost report category of "non-billable expenses." Activities such as end-of-the-day clean-up time, transportation time, consultation and required paper reports are considered to be overhead activities.

Any nursing personnel, quality assurance personnel and/or therapy consultants who do not provide direct, hands on patient care shall be considered administrative and general expenses.

2.135 Inservice Training

The expense of providing inservice training for any of the above personnel shall be included in the calculation of the direct care allowance. Expenses relating to nurse aide training and competency evaluation programs (NAT/CEP) mandated by OBRA shall not be included in the daily rate; separate reimbursement is provided for the direct expenses incurred by a nursing facility for NAT/CEP that is required before an aide can be entered on the Nurse Aide Registry.

2.140 Personal Comfort, Medical Supplies

Personal comfort, medical supplies and other similar supplies, along with special care supplies are included in the direct care allowance. Section 5.100 of this Methods contains further guidelines on, and a list of, the personal comfort and medicine chest-type supplies which are intended to be included under this provision.

2.150 Incontinent Supplies

Incontinent supplies shall include the cost of underpads, blue pads, disposable diapers, reusable diapers, the purchased service costs of a diaper/underpad service, catheter sets and supplies, and bladder irrigation sets and supplies. Section 5.100 of this Methods contains further guidelines on, and a list of, the incontinent-type supplies which are intended to be included under this provision.

2.200 SUPPORT SERVICES ALLOWANCES

The support services allowance recognizes the allowable expenses to provide dietary and environmental services up to amounts payable under Section 3.200. The expenses may include those salaries, employee fringe benefits, supplies, purchased services and other expenses which are directly related to providing the services.

2.210 Dietary Service Expenses

Dietary service expenses are those expenses directly related to the provision of meals to residents of the facility, including dietary supplements and dietician consultants.

2.220 Environmental Service Expenses

Environmental service expenses are generally those expenses related to the provision of maintenance, housekeeping, laundry and security services. Also included are expenses related to residents' personal laundry services, excluding personal dry cleaning services. Residents are NOT to be charged for the laundering of gowns.

2.250 ADMINISTRATIVE AND GENERAL SERVICES ALLOWANCE

The administrative and general service allowance recognizes the allowable expenses for administrative, central office services and management services contract fees up to amounts payable under Section 3.250. The expenses may include those salaries, employee fringe benefits, supplies, purchased services and other expenses which are directly related to providing the services.

2.251 Administrative Service Expenses

Administrative service expenses include those expenses related to the operation's overall management and administration, and other allowable expenses which cannot be appropriately recognized/reimbursed in other payment allowances or service areas. Expenses for the provision of general administrative, clerical, financial, accounting, purchasing, data processing, medical records and similar services are usually considered administrative expenses. Also included are allowable expenses for non-medical transportation, telephone, office supplies, training fees, license fees, insurance (except property, mortgage and general employee benefit insurance), working capital interest expense, amortized financing acquisition costs and other similar expenses. A nursing home may also include the allowable ownership and/or rental expenses of telephone equipment, and computer and electronic data processing equipment. (Inservice training, see 2.135) (Legal expenses, see 1.245) (Interest expense, see 1.270)

2.252 Central Office Costs

Administrative expenses allocated to the nursing home from centralized administrative units of a nursing home chain organization, multi entity or governmental agencies shall be recognized among administrative service expenses, including the centralized unit's allocated overhead expenses such as maintenance, utilities and depreciation. Salaries and fringe benefits for any nursing personnel, quality assurance personnel, and therapy consultants who report to a centralized administrative unit, but do not provide direct hands-on patient care shall be included as central office costs. Expenses may be adjusted by the Department for unreasonable or unnecessary expenses or duplicative services.

A facility that claims both central office expense and in-house administrative and general expense will be subject to the following standards for reasonable and necessary salary and fringe benefit expense in this cost center:

If total in-house salary and fringe benefits **plus management fees** are greater than or equal $6.36 per patient day, no central service salary or fringe benefits is reimburseable.

If total in-house salary and fringe benefits **plus management fees** is less than $6.36 per patient day, then central service salary and fringe benefit expense is **reimbursable up** to a maximum of total in-house and central service salary and fringe benefits **plus management fees** of $6.36 **per patient day**.

2.253 Management Service Contract Fees

Management service contract fees shall be recognized among administrative service expenses, but may be adjusted by the Department for unreasonable or unnecessary levels of service, compensation, or duplicative services. Fees resulting from a percentage of cost or revenue arrangement will be disallowed by the Department, in whole or in part, according to the policy established by the Department. If actual management costs can be documented, those costs (subject to Medicaid allowability) may be substituted for the amount reported up to the amount actually paid.

2.254 Nursing Home Valuations

The cost of Department-required nursing home property valuations conducted by a Department-approved contractor shall be recognized among administrative service expenses.

2.300 FUEL AND OTHER UTILITY EXPENSE ALLOWANCE

The fuel and other utility expense allowance shall consist of allowable facility expenses related to the provision of electricity, water and sewer services, and heating fuel including fuel oil, natural gas, LP gas, coal and other heating fuels.

2.400 PROPERTY TAX ALLOWANCE

2.410 Tax-Paying Facilities

The property tax allowance shall be a per patient per day amount for allowable property tax expense. Allowable property tax expense shall exclude any state property tax credit and any special assessments for capital improvements, such as sewers, water mains and pavements. Whenever exemptions to property tax are legally available, the provider shall be expected to pursue such exemptions. If the provider does not pursue available exemptions, the expenses incurred for property tax shall not be allowed.

2.420 Tax-Exempt Facilities

The property tax allowance for tax-exempt facilities may include a per patient per day amount for the cost of needed municipal services. Includable municipal services will be limited to those services which are financed through the municipality's property tax and which are provided by the municipality to property taxpayers without levying a special fee for the service. A tax-exempt facility may be paying a municipal service fee to the municipality for the services or may provide the service and incur the cost in their own operation.

2.500 PROPERTY PAYMENT ALLOWANCE

The property payment allowance will be a per patient day amount based upon the value of a facility's buildings as estimated by a commercial estimator, target amounts based on service factors established by the Department, and the nursing home's allowable property-related expenses. The estimation will conform with guidelines determined by the Department. This allowance covers, in whole or in part, the nursing home's expenses related to ownership and/or rental of the land, land improvements, buildings, fixed and movable equipment, and other physical assets.

2.600 OVER-THE-COUNTER DRUG ALLOWANCE

The Department will reimburse for nonprescription charges approved by the Department through an over-the-counter drug allowance which recognizes the allowable expenses to provide certain over-the-counter drugs, ordered by a physician, to Wisconsin Medicaid nursing home residents up to amounts payable under Section 3.600. The allowable expenses may include the average wholesale price of the drugs and any pharmacy dispensing costs. Pharmacy dispensing costs shall not exceed 50% of the pharmacy's average wholesale price of the drug.

2.700 PROVIDER INCENTIVES

2.710 Exceptional Medicaid/Medicare Utilization Incentive

Nursing homes, other than those owned and operated by a governmental entity, with exceptional Medicaid/Medicare utilization, described in Section 3.651, may receive the payment incentive. Ownership status is determined as of the last day of the cost report. If a governmental facility changes ownership status, it will not be eligible for this incentive until such time that the change in ownership status has been reflected on the cost report used to set the rate for the applicable rate year.

2.720 Private Room Incentive

Nursing homes may be eligible to receive a Basic Private Room Incentive (BPRI), a Renovation Private Room Incentive (RPRI) or a Replacement Private Room Incentive (RPPRI). To determine eligibility, nursing homes must meet licensed bed and patient day requirements. To receive an incentive, nursing homes must submit an affidavit to the department during the reimbursement year stating that they will not charge Medicaid residents the surcharge for private rooms allowed under HFS 105.09(4)(k) as of the date the incentive would be effective. A private room is a room licensed for single occupancy.

1. Basic Private Room Incentive. Effective 7/1/2000. Nursing homes which meet the both exceptional Medicaid/Medicare utilization, see Plan section 2.710, and have an extraordinary number of private rooms equal to the private room percentage (PRP) listed in Plan section 3.653(a), may receive a payment incentive. This Basic Private Room Incentive is based on the percentage of private rooms to total licensed beds. Licensed bed and private room requirements are listed in Plan section 3.653(a).

2. The Renovation Private Room Incentive (RPRI) is for facilities that undergo substantial renovation for the sole purpose of converting existing space into single rooms subsequent to 7/1/2000. For purposes of this section, substantial means the cost of the renovation project must be at least 25% of the total Undepreciated Replacement Cost, as defined in Plan section 3.531 (b). The RPRI for renovated

facilities will be effective the first day of the month following completion of the renovation or 7/1/2001 whichever is later. The facility must meet the exceptional Medicaid/Medicare utilization in Plan section 2.710 and the private room percentage (PRP) listed in Plan section 3.653(b) after the renovation is complete.

3. The Replacement Private Room Incentive (RPPRI) is for facilities replacing 100% of the patient rooms subsequent to 7/1/2000, and will be effective the first day of service in the replacement facility or 7/1/2001 whichever is later. The replacement facility must meet the exceptional Medicaid/Medicare utilization in Plan section 2.710 and the private room percentage (PRP) listed in Plan section 3.653(b). If a facility does not replace 100% of the patient rooms they may still qualify for the RPRI or BPRI.

2.730 Energy Savings Incentive

If a facility completes a remodeling or renovation project specifically designed to reduce consumption of electricity or heating fuels, or to reduce their electricity or heating fuel rates per unit of energy, the facility may receive an incentive per the calculation method in Section 3.652. In order to qualify for this incentive, the project must have been approved in advance by the Department. During the approval process the Department will consider:

a. The projected savings from the project based on an independent analysis to be provided by the facility. Such analysis may be provided by a public utility or an independent contractor qualified in engineering, architecture, or energy audits.

b. The projected cost of the project.

c. The combined simple payback for all projects proposed for the facility must be less than ten years.

Allowable costs for the incentive will be the lower of: 1) the amount approved in advance by the Department, or 2) the cost of equipment, installation, engineering, energy management and consultant fees prior to rebates. Interest, bond discounts, premiums and financial and/or auditing fees will not be an allowable cost for the incentive.

Replacement boilers that are not part of a co-generation project, replacement central air conditioners, condensers and windows, if included in a project approved or started after 7/1/2000, are excluded from this incentive, although fuel conversion projects are valid projects for this incentive.

SECTION 3.000 CALCULATION OF PAYMENT ALLOWANCES

3.001 Introduction
The payment allowance calculations are described in this section. For the payment system, the calculations of the allowances are on a per patient day basis. The patient days may be adjusted for minimum occupancy.

3.010 The Minimum Occupancy Standard
The minimum occupancy standard is 90.5%.

3.020 Adjusted Patient Day
The term "adjusted patient days" means patient days, including therapeutic and hospitalization bed hold days, as reduced to recognize the 15% reduction on the payment rate for bed hold days and other adjustments determined by the Department. For example, 1000 patient days, including 100 bed hold days, would be reduced by 15 days (i.e. 15% x 100) to 985 adjusted patient days.

3.030 Minimum Occupancy Factor
The nursing home occupancy is determined by the adjusted patient days in Section 3.020 divided by the available bed days (beds for rate setting in Section 3.040 multiplied by the days in the cost reporting period). If the nursing home occupancy is equal to or greater than the occupancy standard, the minimum occupancy factor (Min) is 1.0.

If the nursing home occupancy is less than the occupancy standard in section 3.010, the minimum occupancy factor is:

Min = Minimum occupancy factor
Ratio = The ratio of the actual nursing home occupancy to the minimum occupancy standard

Min= (0.75 * Ratio) + 0.25

3.040 Beds for Rate Setting
The beds for rate setting will be calculated as follows:

- Licensed beds on the last day of the base cost reporting period in section 1.302;
- Less the beds in the bed bank on the last day of the base cost reporting period in section 1.302;
- Less any additional beds deposited after the close of the base cost reporting period in section 1.302 but before July 1, 2001.

3.050 Adjustments

1. If a free-standing ICF-MR facility has decreased its use of unrestricted licensed beds by the lesser of 10 beds or 10%, the facility may request that the reduced number of beds to be used in calculating the patient days at minimum occupancy (Section 3.030). Any resulting rate change is to be effective the first of the month following the decrease in licensed beds.
2. Restricted use beds with a restricted use license issued before July 1, 1995 will be excluded from the beds for rate setting.
3. Beds that are part of RAP projects, as defined in Section 1.240, will be excluded from Beds for Rate Setting if the project(s) is completed by July 1, 2000.
4. Facilities that have qualified for a Section 4.800 adjustment relating to beds out-of-use for renovation projects shall also qualify for a reduction to beds for rate setting. The reduction shall be equal to the monthly weighted average of the beds out-of-use during the cost report period used for rate setting.

3.060 Bed Bank
The Department shall exclude banked nursing home beds from the beds for rate setting (Section 3.040).
For bed bank requests submitted after June 30, 2001, the bed adjustment will be effective July 1, 2002, subject to the Methods then in effect.

If a bed license is split after the end of the cost report period, causing a transfer of beds between more than one facility and there are banked beds on the license, a new rate will be calculated for each facility, effective July 1, 2002, subject to the Methods then in effect, unless Sections 4.400 or 4.500 apply.

3.061 Bed Bank Reductions and Resumption
The Department shall allow the nursing home to exercise the right to resume use of banked beds, unless PERMANENTLY reduced by s. 49.45(6m), with licensure resumption contingent upon receipt of a 18 month prior notice to the Department. Permanent reduction shall occur if any banked beds remain delicensed under this paragraph at the rate of 10% of all remaining delicensed banked beds or 25% of one bed, whichever is greater.

3.062 Bed Bank Restrictions

a. If any of the provisions of Section 4.500 are being applied during the payment rate year to a facility that phases down or closes, then that facility does not qualify for banking of beds.

b. The total beds for rate setting and banked beds cannot exceed the total licensed beds.

c. Banked beds cannot be occupied by any resident. If such use is discovered and such use would raise the number of occupied beds above the number of licensed beds minus banked beds, all beds banked by the facility will be expunged from the bank and the banked beds will be delicensed permanently.

   If such use is discovered but does not exceed the number of licensed beds minus banked beds, the facility has 30 days to correct the occupancy or the beds involved will be expunged from the bed bank and will be delicensed permanently.

d. If banked beds are part of a phase down, the beds will be expunged from the bed bank.

3.070 Exclusions
If the facility has a total of 50 or less beds for rate setting (Section 3.040), including any distinct part ICF-MR or distinct part IMD units in the total facility, they are excluded from the minimum occupancy standard (Section 3.010).

3.100 DIRECT CARE ALLOWANCE

3.110 Types of Payment Rates
The payment allowance for direct care will be computed for each facility so as to establish a rate for each of the following levels of care:

(a) A skilled care rate (SNF).
(b) An intense skilled nursing (ISN) rate.
(c) An intermediate care rate (ICF 1).
(d) A limited care rate (ICF 2).
(e) A combined personal care rate (ICF 3) and residential care rate (ICF 4).
(f) A developmentally disabled 1A rate (DD 1A).
(g) A developmentally disabled 1B rate (DD 1B).
(h) A developmentally disabled 2 rate (DD 2).
(i) A developmentally disabled 3 rate (DD 3).

3.115 Patient Days
Adjusted patient days from the base cost reporting period (Section 3.020) shall be used in the calculation of the direct care allowance. Any patient days classified in a level of care greater than the facility is licensed to provide shall be reclassified downward to the highest level of care for which the facility is licensed. All Medicare adjusted patient days shall be classified as intensive skilled nursing days (ISN).

3.118 ICF-MR Facilities
A facility which has a distinct part certified as ICF-MR shall submit a combined cost report under Section 1.176. Payment rates shall be determined in a combined rate calculation which includes the ICF-MR distinct part and those NF distinct parts which are covered by the combined cost report. This combined calculation of rates shall apply even if each distinct part has a separate provider identification number.

3.120 Method of Computation of Direct Care Allowance

3.121 Inflation Adjusted Expense
The facility's actual allowable direct care expenses for staff wages, fringe benefits, purchased services and supplies shall be inflated/ deflated from the cost reporting period to the common period using the inflation factors in Section 5.310. Dividing the sum of these inflated expenses by adjusted patient days yields per day inflated expenses.

3.122 Case Mix Index
The facility's Case Mix Index (CMI) is the average of the case mix values in Section 5.420 weighted by the adjusted patient days for each level.

The facility's CMI for Medicaid residents (CMI-T19) is the average of the case mix values in Section 5.420 weighted by the adjusted Medicaid patient days for each level.

3.125 Adjustment to Case Mix Index
Facilities that have beds for rate setting (Section 3.040) of fifty beds or less and are certified only as a nursing facility will have a twenty percent (20%) increase in their case mix index. Facilities that are certified as ICF-MR facilities either in whole or in part are not eligible to have its case mix index adjusted under this section.

3.126 Facility Direct Care Target

1. The facility's Direct Care Target is the product of CMI times the Statewide Direct Care Base in Section 5.430, times the Labor Factor in Section 5.410. Hence,

   Direct Care Target = CMI * Statewide Direct Care Base* Labor Factor

2. The facility's Alternate Direct Care Target is the product of CMI times the Alternate Direct Care Base in Section 5.430, times the Alternate Labor Factor in Section 5.410. Hence,

   Alternate Direct Care Target = CMI* Alternate Direct Care Base* Alternate Labor Factor

3.127 Direct Care Common Period Allowance
The facility's Direct Care Common Period Allowance is the greater of a primary and alternate allowance calculation.

1. The Primary Direct Care Common Period Allowance is defined by:

   PriCom = Primary Common Period Allowance
   E = Expense per patient day per 3.121
   T = Direct Care Target per 3.126
   Min = Minimum occupancy factor in section 3.030

   If the expense (E) is equal to or greater than the target,

   PriCom = T * Min

   If the expense (E) is less than the target,

   PriCom = E * Min

2. The Alternate Direct Care Common Period Allowance is Defined by:

   AltCom = Alternate Common Period Allowance
   E = Expense per patient day per 3.121
   T = Alternate Direct Care Base per 3.126
   Min = Minimum occupancy factor in section 3.030

   If the expense (E) is equal to or greater than the target,

   AltCom = T * Min

   If the expense (E) is less than the target,

   AltCom = E * Min

3.128 Direct Care Reimbursement Period Allowance

The direct care inflation increment is the facility's CMI times the Statewide Inflation Increment in Section 5.440.

Inflation Increment = CMI * Statewide Inflation Increment

Primary Reimbursement Period Allowance = Primary Common Period Allowance (PriCom) + Inflation Increment

Alternate Reimbursement Period Allowance = AltCom

No inflation increment will be added to the common period expense in the alternate calculation.

The facility will receive the greater of the Primary reimbursement period allowance or the alternate reimbursement period allowance.

3.129 Allocation by Level of Care
This allocation is done by dividing the Reimbursement Period Allowance by the facility's Case Mix Index prior to the 20% adjustment in Section 3.125, and multiplying the result by the Case Mix Weights in Section 5.420.

3.200 SUPPORT SERVICES ALLOWANCE

3.220 Method of Calculation
Allowable expenses associated with a facility's provision of dietary and environmental services shall be combined, and payment determined, according to the following modified cost formula:

P = Dietary and Environmental services payment allowance

E = Facility's actual allowable expenses for dietary and environmental services (per patient day) adjusted by a composite inflation/deflation factor applied to the common period. The inflation factors are listed in Section 5.320.

Emin = Expense at minimum occupancy,

E * Minimum Occupancy Factor in 3.030

T1 = Target 1 as described in Section 5.510

T2 = Target 2 as described in Section 5.510

I = Per patient day increment under 5.510

If Emin is less than T1,
P = Emin + I + (0.25 * (T1 - Emin))

If Emin is equal to or greater than T1, but equal to or less than T2,
P = T2

If Emin is greater than T2,
P = T2 + (0.05 * (T2/Emin) * (Emin - T2))

3.250 Administrative and General Services Allowances

3.251 Method of Calculation
Payment for allowable expenses associated with the facility's provision of Administrative and General services shall be determined according to the following formula:

P = Administrative services payment allowance

E = Facility's actual allowable expenses for administrative and general services (per patient day) adjusted by an inflation/ deflation factor applied to the common period. Inflation factors are listed in Section 5.330.

Emin = Expense at minimum occupancy,

E * Minimum Occupancy Factor in 3.030

T= Per patient day Target under Section 5.551.

I = Per patient day increment under 5.551

If Emin is less than T,
P = Emin + I + (0.25* (T-E min))

If Emin is equal to or greater than T,
P = T + I

3.300 FUEL AND OTHER UTILITY EXPENSE ALLOWANCE

3.310 Method of Computation

Fuel and other utility expense shall be determined as described below. Payment shall be determined by the following modified cost formula:

P = Fuel and utility payment allowance

E = Facility's actual allowable expenses per patient per day for fuel and utilities as adjusted by component inflation/deflation factors to the common period. Inflation factors are listed in Section 5.340.

Emin = Expense at minimum occupancy,

E * Minimum Occupancy Factor in 3.030

T = Target expense for facility's location. See Section 5.610 for targets.

I = Inflation factor to adjust payment and expense to the payment rate year. (See 5.612.)

If Emin is less than the target

Payment = [Emin * I] + (0.25* (T-E min))

If Emin is equal to or greater than the target

Payment = [T * I]

3.340 On-Site Water and Sewer Plants

For facilities which have on-site water and sewer plants, costs associated with maintaining such operations will be included in the support services payment allowance, not the fuel and utilities payment allowance. For such facilities, the utility target will not be adjusted downward to reflect the absence of costs associated with the water and sewer functions, nor will the support services payment allowance be adjusted upward to reflect the presence of costs associated with the water and sewer functions.

3.360 Seasonal Cost Variations

If a facility's base cost report is not for a twelve-month period, the heating fuel and utility expense shall be adjusted for seasonal cost variations. Whenever possible, a twelve-month period for heating fuel and utility expense should be used with such expenses adjusted to the time period covered by the patient day count. If twelve months cannot be acquired, then heating fuel expenses should be adjusted to a twelve-month period based on heating degree days.

3.400 PROPERTY TAX ALLOWANCE

3.410 Tax-Paying Facilities

Allowable property tax expense shall be based on the tax due for payment by the provider (or the lessor of the building) in the calendar year in which the payment rate year begins times the minimum occupancy factor in Section 3.030. For example, a July 2001 payment rate will include the amount of the December 2000 property tax bill increased by the inflation factor in Section 5.700 to adjust payment and expense to the payment rate year. Alternative cost reporting may be allowed under provisions in Section 4.000.

3.420 Tax-Exempt Facilities

The property tax allowance for tax-exempt providers may include the cost of needed municipal services. For municipal service fees, the expense shall be the expense for municipal services provided to the facility in the calendar year prior to the beginning of the payment rate year as appropriately accrued to that period times the minimum occupancy factor in Section 3.030. The operating expense will be inflated/deflated to the common period by the support services inflation factor. Alternative cost reporting may be allowed under provisions in Section 4.000. The payment rate will include the inflated amount increased by the inflation factor in Section 5.700 to adjust payment and expense to the payment rate year. For operating expenses incurred by the facility, the expense will be from the cost reporting period used for other payment allowances.

3.500 PROPERTY PAYMENT ALLOWANCE

3.510 General

The property payment allowance will be a per patient day amount based on: the equalized value of the nursing home; target amounts based on service factors established by the Department; and the nursing home's allowable property-related expenses. This allowance is intended to provide payment for ownership, and/or rental of land, land improvements, buildings, fixed and movable equipment and any other long-term, physical assets. The asset value of nursing homes acquired at nominal or no cost shall be allowed at the lesser of fair market value or net book value of the owner last participating in the Medicaid program. Depreciation life shall be at the greater of 20 years or balance of 35 years from date of construction. The minimum estimated useful life of used movable equipment will be 5 years. This life will be applied to the composite value of the acquired equipment.

3.520 Allowable Property-Related Expenses

Allowable property-related expenses include: depreciation, interest on plant asset loans, amortization of construction-related costs, amortization of bond discount and premium, lease and rental expenses, and property and mortgage insurance. These costs must be reported in accordance with generally accepted accounting principles (GAAP) and must be necessary for providing nursing home patient care.

The cost reports for the base cost reporting periods and alternative cost reporting periods, as defined in Sections 1.302 and 4.000, will be the source for the information used to determine allowable property-related expenses.

Allowable costs will be adjusted to reflect any limitation on the revaluation of capital assets or lease limitations required under Sections 3.522 or 3.523.

3.521 Maximum on Allowable Property-Related Expenses

Annual allowable property-related expenses will be limited to 15% of the equalized value of the facility.

3.522 Changes of Ownership

If a facility changes ownership on or after October 1, 1985, a change in valuation will be allowed the new owner of the facility. The new owner's valuation will be the lesser of the purchase price or maximum valuation. The maximum valuation is calculated by multiplying the sellers annual asset acquisition costs by year(s) of acquisition times the lesser of one-half of the percentage increase, measured over the same period of time, in the Consumer Price Index (CPI) for All Urban Consumers (United States city average) or the Dodge Construction Index (DCI) applied from the year(s) of acquisition to the date of the sale. The year(s) of acquisition is/are the year(s) the assets were purchased or constructed by the seller of the facility.

If either the seller or the buyer cannot support the individual assets acquired, the historic asset acquisition cost(s) and/or the date(s) of asset acquisition, the following procedure will be followed to impute the maximum allowable value related to capital assets:

1. The ending balance of the total capitalized historical cost of all depreciable assets, from the last available fiscal year cost report of the seller, will be the base value;
2. The ending balance of accumulated depreciation of all depreciable assets, from the same cost reporting period, will be divided by the reported depreciation expense (annualized, if necessary) to impute average years of ownership;
3. The lesser percentage of CPI or DPI described in the first paragraph of this Section 3.522 will be determined based on the imputed average years of ownership and applied to the base value of all assets acquired to calculate an initial maximum;
4. This initial maximum will be compared to 108% of the equalized value described in Section 3.531 below and the lesser value allowed as the maximum allowable value related to all assets.

Where no cost report information is available, the maximum allowable value will be 108% of the equalized value from Section 3.531.

If more than one nursing home is purchased at the same time, the purchase price of all property related assets will be allocated proportionately to all purchased assets based upon an independent uniform appraisal method chosen by the purchasing provider.

This section does not apply to changes of ownership pursuant to an enforceable agreement entered into prior to October 1, 1985.

The costs of acquiring the rights to licensed beds from another provider are non-reimbursable.

3.522(a) Expenses Associated with Change of Ownership Limited by Section 3.522

If a facility's valuation is limited under Section 3.522 the associated depreciation, amortization, and interest expenses will also be limited. Reported depreciation, interest and amortization expenses will be multiplied by the ratio of the above maximum to the actual purchase price to determine allowable expense. If the valuation of assets of the new owner are not limited to the maximum in section 3.522 actual costs will be allowed subject to section 3.520 allowability.

3.523 Lease and Rental Expense

1. Lease Maximum determination for on-going leases. If a facility was leased prior to the current cost reporting period, the maximum allowable lease expense for the current cost report period, will be limited to the lower of the actual lease payments or the total of the allowable lease expenses from the previous years cost reporting period multiplied by one-half of the percentage increase (as measured over the same period of time) in the Consumer Price Index for all Urban Consumers (United States City average).

2. Lease Maximum determination for previously owned but never leased. If a facility is leased during the current cost reporting period but was not previously leased, the allowable maximum lease expense will be determined by reference to the current owners year(s) of acquisition of the facility's fixed assets to the current cost reporting period. The year(s) of acquisition is/are the year(s) the facility was purchased or constructed by the owner. The lease maximum will be determined by: a) If the facility is still owned by the original provider that constructed the facility- divide the original cost(s) of construction/acquisition adjusted by one-half of the Consumer Price Index, by the original costs(s) of construction/acquisition; or b) If the facility was previously purchased – divide the allowable purchase price adjusted by one-half of the Consumer Price Index plus capital additions, by the allowable purchase price plus capital additions from the cost report used for rate setting prior to the lease (per Section 3.522). This ratio will then be applied to the allowable property expenses, related to the assets now leased, and that were included in rates effective June 30, 2000 to determine the maximum allowable property expense subject to number 5 below and Section 3.523.(a). The lower of actual or calculated maximum lease expense shall be used for determining the property reimbursement under Section 3.530.

3. Lease Maximum determination for new or replacement facilities. For new or replacement facilities that began operation in the cost report used for 2001-2002 rate setting, the lease expense paid is the maximum allowable for 2001-2002 subject to all other cost standards and formula limitations.

4. Lease determination for a sale and lease back. For purposes of this section, an unrelated party sale and lease back transaction will be limited by the percentage increase that would be applied if the facility had been leased prior to the base cost reporting period. The lease maximum shall be determined by applying one-half the increase in the CPI from the year of the sale to the allowed reimbursable property expenses for the assets that are now leased from the year before the sale.

5. General provisions of allowable lease determinations. This limitation will only apply to lease expense and other capital costs as of the date of lease inception. It will not apply to depreciation, interest, lease and rental or other property costs on assets, whether the lessee or lessor acquired the assets after lease inception, such as the purchase or leasing of new equipment or leasehold improvements.

If a facility is unable to provide adequate support of the dates of asset acquisition, the procedure under Section 3.522 for imputing average years of ownership may be applied.
Lease expense includes the actual payments required under the lease contract. Lease expenses determined under the capitalized lease method of Financial Accounting Standards Board Statement No. 13 will not be recognized.

The costs of acquiring existing leasehold rights are not allowable.

3.523(a) For leases existing prior to the cost report used for 2001-2002 rates, the limit calculated under this section will be increased for depreciation and interest expenses incurred by a lessor for leasehold improvements completed on or after July 1, 2001. The amount of increase will be calculated as if the lessee had made the improvements. This increase will be allowed only after a written agreement by the lessor has been received by the Department guaranteeing access to all records relating to the claimed expenses.

3.524 New Facilities, Replacement Facilities and Significant Licensed Bed Increases or Decreases after July 1, 2001
For new facilities licensed after July 1, 2001, and facilities with significant licensed bed increases or decreases after that date (as defined in Sections 1.305 and 1.304 respectively), the property payment allowance will be recalculated using the cost reporting periods and procedures described in Sections 4.300, 4.400, or 4.500.

The property payment allowance will also be recalculated when a facility has replaced a significant number of licensed beds. ("Replacement" is defined in Section 1.306.) (A "significant" replacement is defined as the replacement of the lesser of: (1) 25% of licensed bed capacity or (2) 50 beds.) When a significant replacement has occurred, the property payment allowance will be based on at least a six-month cost reporting period which begins within five months after the first of the month following licensure of the replacement bed area. The adjusted property payment allowance will be effective as of the date of licensure. No phase-in or start-up provisions will apply to property payment allowances for facilities receiving adjustments for replacement facilities.

3.525 Depreciation and Amortization

1. Amortized A & G expenses. Amortization of the costs related to acquiring financing (i.e., bond issuance costs, bond placement fees, and letter of credit fees) are not considered property-related expenses but are allowable expenses under the administrative and general component. Financing fees include such items as, but not limited to, finder's fees, credit checks, origination fees, appraisal fees, feasibility studies, and loan application fees. Amortization of such fees is allowable in A & G. Write off of the